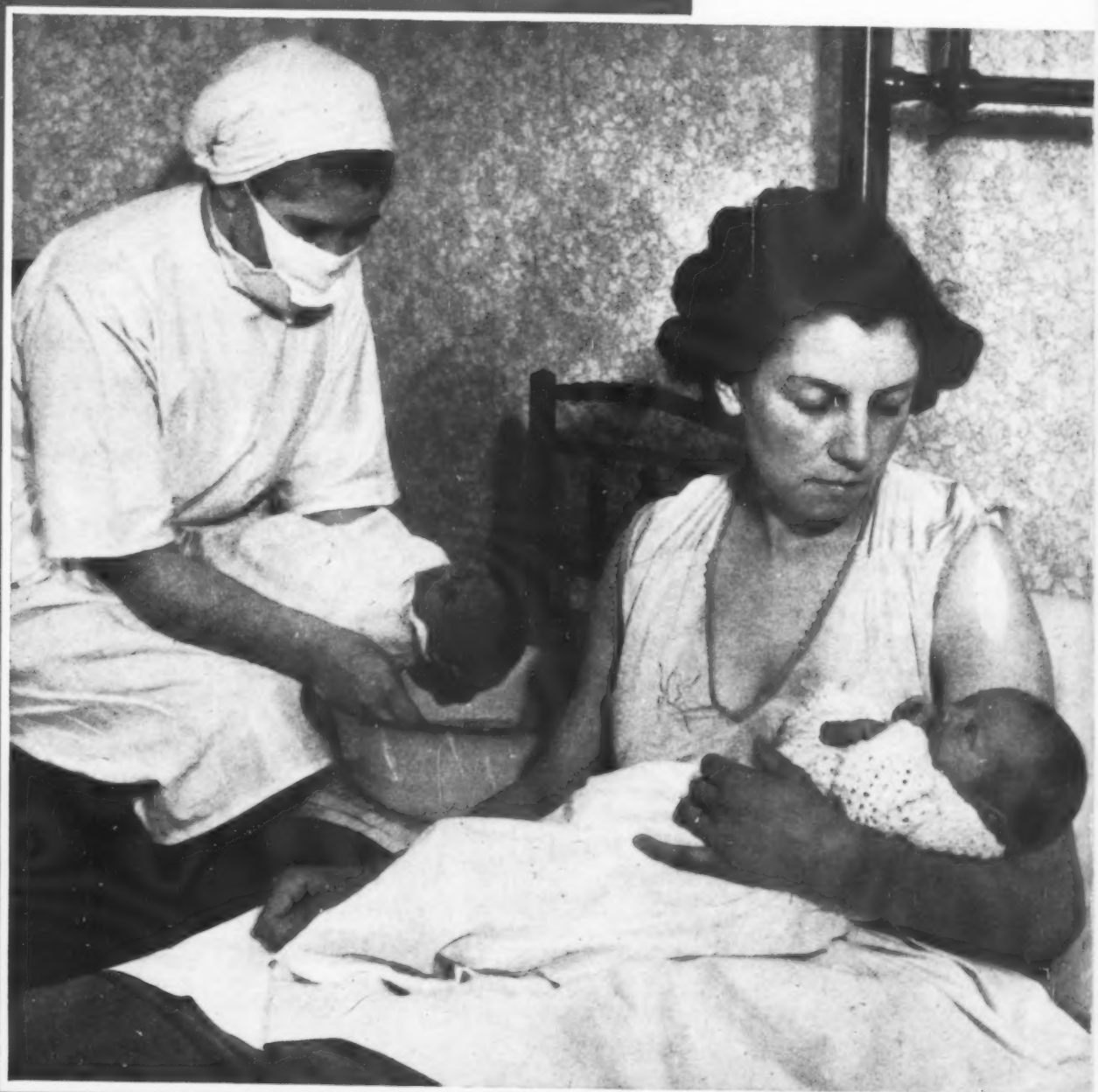
District Nursing

MAY 1958

ONE SHILLING



DISTRICT NURSING • MIDWIFERY • HEALTH VISITING

Queen's Nurses' Benevolent Fund

ANNUAL MEETING
AND BRING AND BUY SALE

Please book the date—Friday, June 6th 1958

Time—3 p.m.

Place—Hackney District Nursing Association,
6 Lower Clapton Road, London, E.5

COME to the Annual Meeting to hear about the work of the fund. Miss E. J. Merry, President, will be in the Chair.

Miss G. M. Ironside, Superintendent of Hackney D.N.A., will be pleased to receive your gifts for the Bring and Buy Sale, if you cannot attend personally.

Please support this effort for the funds that exist to help Queen's Nurses when off duty through illness.

Such help has been given to the under thirties, and is being given still to the over eighties—all are colleagues—help the Committee to help them by your support.

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The decline may be attributed in the main to advances in environmental sanitation and disease control, and it is reflected in increased life expectancy almost everywhere. In the more developed countries a new-born girl can be expected to live 4–5 years longer now than 10 years ago, a new-born boy 3–4 years longer; and in some of the countries undergoing rapid development, life expectancy at birth has increased up to 11 years for girls and 10 years for boys.

With a decreasing rate of death and an almost unchanged birth rate the population of the world (now about 2,700,000,000) is growing rapidly: every hour almost 5,000 persons are added, or 120,000 per day, or 43,000,000 per year—an increase calculated to double the world's population by the end of the century.

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Both are doing well

Fewer and fewer women die in childbirth and more and more babies survive their first step into this world.

In some countries, a 90 per cent. decrease in maternal mortality has taken place during the last 20 years. In 1955, the maternal death rate, as calculated per 1,000 live births, was lowest in New Zealand: 0.4; 20 years ago it was 3.8. The decrease is most spectacular in the countries undergoing rapid development, for example Ceylon where the drop was from 20.5 in 1936–1938 to 4.1 in 1955.

As regards infant mortality, the lowest rate in the world is recorded in Sweden, where it dropped from 22 per thousand live births in 1951 to 17 in 1956.

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However, with the insecticides and drugs that are now available, malaria eradication is possible almost throughout the world, provided that campaigns are pushed hard enough before insect-resistance to spraying develops.

Some regions are close to the goal: in Southern Europe, 4,000,000 new cases a year were reported before the introduction of DDT spraying—now less than 10,000 a year. In the Union of Soviet Socialist Republics there were some 4,330,000 cases of malaria immediately after World War II. In 1956 fewer than 13,000 new cases were found and no new infections are expected to occur after 1960. In the Americas, malaria once menaced 135,000,000 people. To date 105,000,000 have been protected and the vigorous campaigns now going on are expected to complete the protection within a few years. In Africa south of the Sahara, malaria presents the most serious and difficult problem with which the specialists are confronted. Nevertheless, at the end of 1955, 14,000,000 of the 116,000,000 Africans living in malarial regions had been protected against the disease.

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Also deaths from degenerative disease of the heart and arteries (the most frequent cause of death in North America and most of Europe) are increasing. Among the possible causes is the aging of the population and consequent swelling in the 40–80 age-group in which these diseases are most prevalent. Also, diagnostic techniques have improved, decreasing the number of deaths formerly attributed to "senility" or to "unknown causes".

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Nevertheless, tuberculosis is still the greatest killer of all infectious and parasitic diseases, and in North America, Europe and Australia, it accounts for three-fourths of all deaths from these diseases occurring after the age of 15.

A considerable change in the age distribution of deaths from tuberculosis of the respiratory system has taken place: before World War II the majority of victims were women between 20 and 30 years of age and men between 40 and 55. Now, deaths are most numerous among people over the age of 60, women and men alike.

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Nevertheless, pneumonia still ranks among the 10 diseases causing the greatest number of deaths in the more developed countries. It remains one of the three leading causes of death among infants, and is even more serious among the aged.

Little variation in the death rate for pneumonia is at present being reported from one year to the next, and it can be assumed that it will remain at the present level for some years to come.

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Although still the most deadly of infectious diseases for children, whooping cough is on the retreat. In 28 countries all over the world, deaths from this disease dropped from 26,325 in 1950 to 10,376 in 1955. The highest death rate is among children less than one year old but it is in this age-group also that the decrease is most striking: from 7,874 in 1950 to 1,623 in 1955.

Whooping cough is unique among the diseases of childhood as it usually strikes and kills more girls than boys.

Greatest vaccination campaign

In history's greatest campaign of immunization, 192 million people have been tested, and 74 million vaccinated against tuberculosis with BCG (Bacillus Calmetto-Guérin) between 1948 and 1957.

The work was started in war-torn Europe by Scandinavian relief organizations and later expanded to the other continents with the aid of WHO and UNICEF. Since 1951 the campaign has been supported by these two international bodies in close co-operation with the governments concerned.

By far the largest part of the programme, both with regard to the number of countries and the number of persons involved, has been carried out in Asia.

There are now 1,236,000 physicians serving the world's 2,700,000,000 inhabitants and the 638 medical schools operating in 85 countries graduate annually about 67,000 new doctors.

There are 14 countries fortunate enough to have one doctor to serve every thousand or fewer people. But there are 22 others where there is only one doctor for 20,000 or more inhabitants. Between these two extremes, the rest of the world shows great variations.

Florence Nightingale Scholarships

Scholarships awarded through the National Florence Nightingale Memorial Committee 1958/59 session.

B.R.C.S. SCHOLARSHIPS for State Registered Nurses to study outside this country.

Miss M. E. Coombe—(£350 full scholarship) Matron, General Hospital, Northampton, and Branch Nursing Superintendent B.R.C.S., Northampton, to assist her in studying Nursing & Training School Administration in the U.S.A. and Canada.

Miss O. Walden Jones—(£350 full scholarship) Principal Sister Tutor, St. George's Hospital, London, and Nursing Superintendent in the County of London Branch B.R.C.S., to assist her in studying Nursing Education in the U.S.A. and Canada.

THOMAS WALL TRUST FUND SCHOLARSHIP (£350).

Miss M. Rowe (£350) Surgical Ward Sister, St. Thomas's Hospital, to assist her in studying Ward Administration in the U.S.A. and Canada.

NATIONAL FLORENCE NIGHTINGALE MEMORIAL COMMITTEE SCHOLARSHIP 1958/9

Miss M. Kneale Jones (£350 scholarship) Deputy Theatre Superintendent, The London Hospital, Whitechapel, E.1., to assist her in studying Operating Theatre administration in the U.S.A. and Canada.

Nuclear Training for HEALTH PERSONNEL

AT a Royal Society of Health symposium on the Training of Local Authority and Hospital Personnel in Nuclear Radiation Hazards, Mr. G. B. Courtier, B.Sc., D.I.C., F.R.I.C., M.R.S.H., Senior Principal Scientific Officer, London County Council said :

The extent to which trained local authority personnel can play a part in detecting and limiting possible environmental hazards is dependent not only on their ability to appreciate the nature of the problems which may arise, but on the instrumental facilities available for measurement. For some purposes portable equipment can give the necessary information, but where there is low-level though persistent contamination of the atmosphere, drinking-water supplies, or food, the position can be assessed only by laboratory methods using costly radiochemical apparatus.

This is a field of activity for the public analyst, and it would seem that some of the skill and painstaking effort which has been employed in the past in protecting the public against various chemical contaminants in food must in future be directed towards ensuring freedom from radiochemical contamination.

Mr. Carling continued that it was the traditional duty of health officers to prepare themselves against rare and baneful eventualities, and in spite of the elaborate precautions which are taken to ensure safe operation, the possibility of future accidents, perhaps from another type of reactor, can never be excluded. In such an event, health personnel with suitable training and facilities could usefully co-operate with the more sparsely distributed nuclear specialists in defining and limiting the hazards.

Health personnel should therefore be trained in the knowledge of the particular hazards which could arise from local installations, and close liaison should be maintained between all the authorities concerned. The need for such liaison was affirmed by the recent Fleck committee on health and safety in nuclear installations.

The Windscale accident and the impending operation of new reactors gives a sense of urgency to the position, and several local authorities are looking into the possibility of measuring the present background of radiation to provide a basis for future comparison. Whatever the immediate findings, this can be regarded as a useful phase of training for personnel. Such techniques of measurement have been explored for some time in the laboratories of the London County Council.

The general findings have been that sources of radiation to which the public are exposed at present, in excess of the natural sources, amount to only a small fraction of this natural quota. The nature and amount of these small traces can be assessed only in a well-equipped radiochemical laboratory. On the single occasion of the Windscale accident the amount of air-borne matter was sufficient for detection by simpler means although the findings could not be adequately interpreted without fuller analysis.

No. 2. A District Nurse's View

The Superintendent, District Nurses' Home, Plymouth, continues our series on the different branches of the National Health Service

The Link to Health

by DORA M. WILLIAMS, S.R.N., S.C.M., M.T.D., H.V. Cert.

THE dictionary defines the word "link" as "a component part of a connected series, in which if one link fails the whole fails". If these links between the hospital, general practitioner and district nurse fail, the *service* to the patient fails, and that is the important thing to remember. It is not the individual success of a part of the health service, but the result of the whole scheme, to the *patient*.

In order to make these links as smooth and unbroken as possible, it is imperative that we should know and understand one another's work, and have a sympathetic understanding of one another's problems.

First let us consider the link with the general practitioner. It is usually a very happy one, because the contacts are easily made, and even if the doctors are not known personally, their voices are usually familiar. How often have I been astounded at a meeting, when the voice has not matched the imagined figure!

Second Opinions

The object of our collaboration with the general practitioner is, of course, to care for the patient, jointly. We each have our part to play. For perfect co-operation no difference of opinion should be shown to the patient.

I always advise a student district nurse to be absolutely loyal to the family doctor and not to be led into any criticism, said or implied. So often we hear the patient or relative ask the nurse if she does not think that some other treatment would be more beneficial, or some other doctor should be called in. It is always wise to suggest that the proper way to deal with such matters is to discuss it with the doctor in charge. The nurse herself can, if she wants to, call on the doctor or speak to him on the telephone—and then she can say what she likes!

We expect, and usually receive, the same loyalty and support from the doctors, although occasionally I have been rung up by an irate physician accusing a nurse of suggesting to the patient that all is not being done that might be. When the facts are known, very often it was merely a third hand report, wrongly interpreted; and also occasionally a doctor may criticise the nurse's method or attitude to the patient. This sort of thing merely divides loyalties, and undermines the patient's trust in the health team, and should be avoided even at the risk of a personal injustice.

It must be remembered that since the Health Act came into force, the doctors find it impossible to visit and carry out all the treatment for their patients personally, as they used to do in the past. For example, the increased use of the antibiotics to counteract infection, usually means a daily visit for five to seven days. The nurse now gives these injections and reports to the doctor when necessary—thus co-operating with the doctor in his work, and helping him to have more time for visiting and diagnosis. The whole idea of the Health Service is to encourage the patients to seek early advice, and if the district nurse can in any way help the doctor to make this more possible, she should be proud to do so.

To achieve good co-ordination each must have a reasonable knowledge of one another's work and problems. The nurse must find out the best times to contact the doctor and educate the general public in how to use the family doctor service. The doctor must make it his business to find out how the home nursing service works, when and how to contact the nurses, and any particular difficulties that may be prevalent in the area. For example, the times the nurses start out to work is important. It is maddening to receive a new case just as they have all gone!

If the doctors knows that they can usually speak to the nurse personally between 2 and 4 p.m. it prevents many a wasted call, thus saving time and money. The more we learn about one another's work, the better we shall be able to co-operate.

Much can still be done by nurses being asked to address local medical meetings and doctors being invited to nurse's staff meetings. In country areas the nurse finds it easier to contact the doctor personally and probably will visit his house or surgery for a few minutes each day. In the future, health centres, if developed, will of course be a meeting place for all members of the health service.

Helping Medical Students

Already a general practitioner is asked to give a lecture to student district nurses on his aspect of the work; and this might well be reciprocated by medical students having a lecture from a superintendent of home nursing, to prepare them for working with the district nurses in the future. In some enlightened hospitals the medical students are introduced to several branches of the health service. Much more of this could be done to advantage. The poor doctor, on qualifying, is ill-equipped for general practice and needs all the help he can receive.

When the nurse and the doctor have good co-operation the patient feels that she is being cared for by a single

service and not several different parts. It is comforting to know that the doctor is kept aware of her progress.

Turning now to the co-operation between the hospital and the district nurse, we at once come upon difficulties because we are no longer dealing with two individuals, but with one individual and a whole complex service.

When enquiring what treatment was needed for a certain patient on discharge, I first asked the almoner for information. I was told to ring the records department, who told me to ring the ward sister, who said it was the house surgeon I needed. At last I was told that the surgeon would write a letter! Meanwhile the patient was not having the necessary treatment continued.

All district nurses know and appreciate hospital work, as they all trained there; but few hospital workers have any idea of either the working of the health service or the district nursing service. For instance patients are discharged without being made to understand that it is the doctor who should prescribe dressings and drugs. They often think that these will be brought along by the nurse!

It is vitally important that the treatment and care of the patient should continue unbroken. Not long ago the Minister of Health issued an eighteen page circular on how to receive a patient into hospital. Two lines only, were devoted to the discharge from hospital! This omission could, with advantage, be remedied.

To ensure unbroken treatment for the patient, drugs and dressings must be at the house, in time, and this presents a great problem. The general practitioners are seldom told in advance of a patient's discharge from hospital, and the specialist's letter only follows days after. True, the almoner, ward sister and house surgeon, do, at times, contact the district nurse direct, or give the patient a note for her ; but this is not, and cannot, for domestic reasons, always be delivered in time. And even after the doctor has prescribed the drugs and dressings they have to be obtained from the chemist, sometimes miles away. This is the sort of thing we must try to improve.

I believe that in Cambridge no patient is discharged without prior consultation with the general practitioner and the district nurse.

Another example of how a break in care can cause the patient distress at times, is when they are discharged from hospital with stitches still in. The nurse is asked to call on the seventh or eighth day after operation to remove them, and if the patient has been at home for several days before this, they are often extremely worried. A surgical dressing and no one to look at it, is alarming to the lay mind. An earlier call, if only to inspect and reassure, is often a great comfort to the patient.

Already there is an improvement in the co-operation between hospital nurses and district nurses, and this is likely to increase, as the student nurse now has lectures, and usually some practical experience of the public health field, in particular of the home nursing service, during her training. If that could be extended to medical students as well, we should be well on the way to having the links between the hospital, general practitioner and home nursing service well and truly forged, and so get the patient unbroken care with a smooth transition, between those three parts of the National Health Service.

Next month Miss R. Bonsey, A.M.I.A., Head Almoner, Bristol Royal Hospital, Royal Infirmary Branch, presents the Almoner's viewpoint

Danger on the Wing

SUGAR, jam, milk, and most uncooked foods that are often left uncovered, attract the housefly; but so also do human and animal dejecta and discharges. The fly feeds greedily upon them, swallowing the bacteria which are present, and deposits the disease-germs on exposed food, in addition to the contamination which may be transferred directly by the feet of the fly.

Garbage, house refuse and manure are the main breeding grounds of the housefly. To prevent breeding, all dustbins and pig-bins should be kept covered with a properly fitting lid, and emptied at least weekly.

Screening is the obvious way of keeping flies out of the house. Larders can be protected by covering the window with a fine wire gauze and keeping the door shut.

Flies breed in rotting food and vegetables, so stores should be looked over and not left to lie rotting. Kitchen waste should be kept in a covered tin or bucket until cleared away.

Sour milk is another focal point. Bottles should be well rinsed with cold water when emptied, not left to stand with the milk dregs in them. The thorough cleaning of all food vessels as soon as possible after use is advisable against attracting flies.

All food including milk should be kept covered. Food should not be taken from the protected larder and left standing uncovered on any table.

If a dining table is laid in advance of a meal, food should all be covered, or better still, a clean cloth laid over the whole table and its contents.

Effective destruction of the housefly can be achieved by fly papers, fly sprays, and poison bait.

One type of spray has an immediate " knock down " effect on contact with the fly, whether at rest or flying about. The other has a slower but more lasting effect by the deposition of a fly-killing film upon surfaces where flies alight or congregate. This type of spray containing D.D.T. or a similar preparation should therefore only be used on areas where flies usually settle, such as windows, window sills, lamp shades, hanging pictures and the like.

Some sprays contain kerosene or other inflamamble contents, and if so must not be used in the presence of fires or naked flames. Smoking too should be prohibited during the actual operation. Care must also be taken to prevent the spray falling on to food or feeding utensils and the like.

Poison baits are cheaper but less effective in damp weather. Formalin is prepared by the mixing of one heaped tablespoonful of sugar with one teaspoonful of commercial (40 per cent) formalin and the addition of water or preferably lime water to half a pint. A little of this solution may be placed in a saucer, but it is better if layers of blotting paper or pads of cotton wool soaked in the fluid are exposed in suitable places.

Formalin is a poison and must be kept well out of reach of children and pets.

A selection from some unpublished letters recently discovered in Queen's Institute files

The Letters of Florence Nightingale

Claydon House,
Winslow,
Bucks.
Aug. 9/87

Dear Mr. Rathbone,

I am more than sorry. I am grieved and cannot express my regret that you have been kept waiting so long for your paper.

Mr. and Mrs. Craven told their Committee, as of course you know, of the Scheme on foot some time ago. She was asked by the Duke of Westminster to make suggestions and did so. But the Committee had no voice in the matter and were not given an opportunity of saying anything. The idea was said to be to assist in planting a District Nurse in different provincial towns throughout the country.

(She asked to see me; but work and illness interfered. I regret very much now that I did not break thro' these things and see her—tho' I had seen her two or three days before.)

Did you see Mr. Craven, as, when you wrote to me, you proposed? It is said that Mrs. C. will be an obstacle to anything like this.

I was obliged to consult Bonham Carter on your paper. And I have not received his answer till this morning.

I feel how excessively meagre our " Suggestions " are —and how vain is criticism, if one does not propose and find some scheme, or offer some plan, for raising the standard of work (which perhaps only individuals can do by *their work*).

Most heartily do we wish you success—for to obtain a good sum of money to promote the objects of the *M. & N.N. Assn., which you yourself have founded and so nurtured, would be a grand thing to do.

Accept our earnest apologies and good wishes and believe me,

dear Mr. Rathbone,
ever yours gratefully and faithfully
F. Nightingale

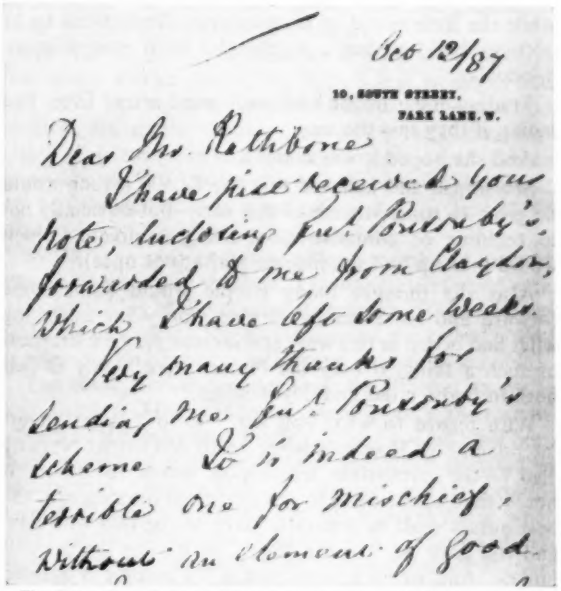
I pray for your success in that of the M. & N. N. Assn. and I deeply sympathize with you in all.

**Metropolitan and National Nursing Association*

Aug. 14/87

Dear Mr. Rathbone,

I am exceedingly grateful to you for your great kindness in writing to me in the midst of your heavy occupations—I assure you it was an unexpected kindness. I telegraphed only because it came suddenly into my head


Dec 12/87
10, SOUTH STREET,
PARK LANE, W.
Dear Mr. Rathbone
I have just received your note, inclosing Genl. Ponsonby's. forwarded to me from Claydon, which I have left some weeks.
Very many thanks for sending me Genl. Ponsonby's scheme. It is indeed a terrible one for mischief, without an element of good.

The Ponsonby scheme referred to was a non-contributory scheme for all types of trained nurses who would be selected for awards

that you might have set on foot those important measures in the (wild-beast sort of a) House of Commons, and then been going abroad last week and thinking: ' She has not sent me back my papers; and now it's no use '.

It was very, very kind of you to write.

After I had sent your papers, I saw a lady who had had a great deal to do with the Jubilee Fund and seemed to have more sense than the others put together, who told me (but I dare say you know much more than this) that, after the statue will have been paid for, there will be an income of about £2,500 a year; that it is particularly desired to spend no part of the capital of this (about £60,000) on building; (£60,000 goes but a little way in building, she said)—or on any new organization, but on *live* stones, to be called the Queen's Nurses, to nurse the sick poor at their own homes.

She thought the £2,500 a year would be all given to this one purpose, if a fit scheme could be made—She thought it should be attached to some Hospital, to save any *new* organization. (We, of course, do not think *that*, not to any *one* Hospital, except in the way that they should be all *Hospital*-trained Nurses).

She spoke *most highly* of the *objects* of the M. & N. N. Assn., but said that the Queen's Nurses should not be all " ladies ". She said this quite simply, not as if there

had been a controversy. Possibly hereafter we may find that the better class of ordinary Nurses make under supervision good district Nurses and the superior class even alone.

We have not yet succeeded in enlisting the better sort of women of tradesmen's families, who generally lead the most useless or uninteresting lives—unlike those of ladies, so improved in usefulness, in interest, in what public opinion allows them to do, in the last 30 years—while the little world of tradespeople allows them to be nothing but 'genteel', except the most energetic individuals.

Tradeswomen might lead such good active lives, like ladies, if they saw the way.

And she hoped it was coming.

She hoped and believed that the £2,500 a year would be given to some scheme of this sort—but especially *not* to building or administration, i.e. government (which would take up half the income perhaps at once).

Also she thought many people would soon come forward and leave money or give money for endowing what had begun in this way, and increasing the usefulness of such a thing, if only the Nurses were highly skilled both in body, mind and devotedness.

With regard to what you say. As to "ladies superintendents—of Hospitals being heads of District Nursing also"—the irresistible temptation seems to be—is it not?—that where there is private (paid) nursing too, the best nurses must be generally given to the rich who pay, and the poor go "to the Wall" in having the poorest nurses. And where a large part of the income is derived from the payments of the rich, this is more unavoidable by the Superintendent than it sounds.

(N.B. "ladies" are more fitted for District than *Private* Nursing)

Indeed, how often it has happened that, where Private Nursing has been combined with District Nursing, it has ended in District Nursing being given up altogether as, e.g. the Westminster Hospital and its Nurses' Home, and the Lady Augusta Stanley Fund which were understood —were they not?—to be expressly for *District* Nursing. And now they have an immense *Private* Nursing Staff, and not one District Nurse, and actually had to apply to Bloomsbury for one.

I repent putting this on paper to trouble you with, because certainly you, who are the founder of District Work, should know better than I.

Deeply I have felt throughout what you say: "the difficulty to get the Q.'s Jubilee Fund &c &c without hampering and degrading work already going on". But I trust in your overcoming it.

I will not trouble you any more to-day. God bless all your work.

Ever faithfully and gratefully yours

F. Nightingale

Excuse pencil and scribble

Sept. 1/87 6 a.m.

Dear Mr. Rathbone,

I rejoice that you have seen Major Tully, that you find him sensible, and that some progress is being made in the right direction towards application of the Queen's Jubilee Fund.

(N.B. I quite concur with you that as pickpockets must not know one another in a crowd, so we had better not know one another in getting an use for the Queen's pocket).

Thank you very much for sending me a Proof of your valuable paper, which I return. It seems to me that you have made all the suggestions good at this stage—and I have only made a verbal correction or two.

Farther development will of course be needed from you at some further stage.

I am so thankful that this has been so well begun.

Good speed to the work.

I keep the other Proof for my own good.

Yours ever faithfully and gratefully,

Florence Nightingale

I am glad that Mr. Bonham Carter has had direct communication with you.

I do not like to keep your Memo any longer, as you wish to save time—I will return your letter to Major Tully immediately.

10, South Street,
Park Lane, W.
Oct. 12/87

Dear Mr. Rathbone,

I have just received your note, enclosing General Ponsonby's, forwarded to me from Claydon, which I have left some weeks.

Very many thanks for sending me General Ponsonby's scheme. It is indeed a terrible one for mischief, without an element of good.

I must cry you mercy for to-day, for I am rather overdone.

Sir Rutherford Alcock has written to ask to see me about the Jubilee Fund. I cannot see him this week. But I shall be glad to have known this about General Ponsonby when I see him.

In haste
Ever gratefully yours

F. Nightingale

You probably know that Bonham Carter has gone to America for two months.

I hope it will not be till December that the scheme for the Jubilee Fund will be finally decided.

I trust to write tomorrow about General Ponsonby's scheme according to your kind desire.

You must have most kindly given orders for the Nurseryman to begin again with your beautiful flowering plants. For he has done so, to my shame and my gratitude. *F.N.*

To be continued next month

The founder of the Plunket system

New Zealand Baby Care Reformer

LAST month saw the centenary of the birth of Sir Frederic Truby King, the New Zealander whose system of infant welfare swept his own country fifty years ago and gained fame throughout the world.

In New Zealand they call it the Plunket system, named after the wife of the then Governor, Lord Plunket, who showed the keenest interest in Truby King's efforts to establish it. Today about 90 per cent of all babies born in New Zealand are brought up under the Plunket system.

At the turn of the century Dr. Truby King who was medical superintendent at Seacliff, became interested in the scientific rearing of plants and animals on the large farm attached to the hospital. At the time of his arrival twenty per cent of the calves on the thousand-acre farm died every year from " scouring "—a disease essentially the same as diarrhoea in babies. He instituted a system of rational, scientific, artificial feeding for the calves based on the percentage composition (and especially the protein ratio) of the calf's natural food. As a result the mortality from scouring was entirely wiped out.

'Natural Feeding'

Truby King became convinced that if the same scientific care were given to the rearing of babies as was given to stock, many infant lives could be saved. He believed that at least half the deaths occurring during the first year of life could be prevented and that a great deal of ill-health and malnutrition was due solely to parents' ignorance. He came, in fact, to be an unceasing advocate of natural feeding, and he embarked on a New Zealand-wide campaign to promote this, as well as his simple principles of scientific child care. These had as their cornerstone that where natural feeding was not possible any artificial food should be as close to the natural milk as it was possible scientifically to make it. He prescribed milk sugar as the sugar choice for infants and devised a cod liver oil emulsion as a supplement to all modified milk mixtures.

Over a period of some years Truby King gave New Zealand a practical demonstration of the efficacy of his methods. A severe epidemic of infantile diarrhoea was sweeping the country and in Dunedin claiming 25 deaths for every 1,000 live births. As a result of the work of the Truby King Mothercraft Society these deaths were reduced at the end of five years to nine in 1,000 live births; in the next five years to four; and in the following five years to less than one. In the three years that followed not one single baby in Dunedin up to the age of two years died from any form of diarrhoea, which had been the greatest scourge of infancy.

Today New Zealand has the second lowest mortality rate in the world.

The primary function of the Plunket Society is to disseminate knowledge and advice. In the end, results depend upon the individual mother and every effort is made to educate her in infant welfare.

All mothers in New Zealand are entitled to the society's free home service during the baby's first weeks of life, and later to the clinic service. Infants and pre-school children are seen at regular intervals by the nurses, who check their progress and advise mothers on all aspects of child care. Clinics for the care of pre-school children are rapidly increasing in popularity and more than 70,000 pre-school children are under supervision.

In the four main centres a sister is employed to teach groups of expectant mothers the rudiments of child care.

The teaching of mothercraft to schoolgirls is encouraged by the Education Department and a prescribed course is given by Plunket nurses in many secondary schools.

The clinic service operates from the Plunket rooms in each district. The building of these rooms is the responsibility of the individual branch. Some rooms have been built entirely by voluntary labour and others donated by benefactors. In some districts voluntary workers provide a room in their own home for the Plunket nurse when she is visiting their area. To cope with the needs of new State housing settlements, fully equipped mobile Plunket units have been acquired.

There are also six Karitane hospitals, used as institutions for the training of Karitane nurses. These girls, from the age of 17, enter a Karitane hospital and do a 16 months' course in mothercraft. After that they stay in private homes and help mothers with their babies.

Royal Visit

The Dunedin Karitane hospital, visited by the Queen during her tour of New Zealand in 1953–54, is the Dominion training school for Plunket nurses. Here a course is available to those who have completed both their general nursing training and their training in either maternity work or midwifery.

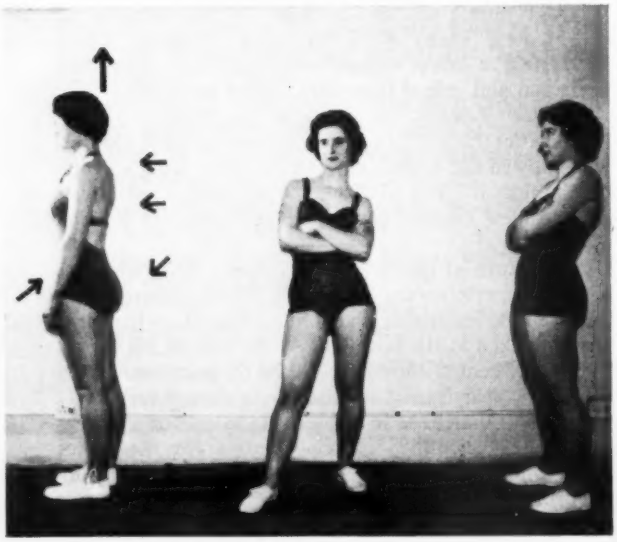
At the University of Otago, the Lady King Scholarship is available each year to a medical graduate to study problems of the infant and young child. This year a study is being made of the drug-resistant organisms which are a hazard to the newly-born in maternity hospitals.

Sir Truby King personally founded the Mothercraft Training Society in London, the Australian Mothercraft Society of Sydney, and the Mothercraft Training Centre in Capetown. In 1931 the Canadian Mothercraft Society was founded in Toronto by Mrs. Irving Robertson, a New Zealander. There are also societies operating the system in Victoria, South Australia, Tasmania, and in Israel.

Posture and Body Dynamics for District Nurses

Adapted from a film strip prepared by the Queen's Institute in co-operation with St. Thomas' Hospital School of Physiotherapy, and produced by 'Camera Talks', London

The application of the principles of good posture and body dynamics by the district nurse to her work will help her to carry out her duties without undue expenditure of effort or the risk of spinal injury. The far-reaching effects of this can be appreciated when the heavy physical demands entailed by district nursing are considered, especially the single-handedness and the difficult conditions of cramped surroundings and low beds.

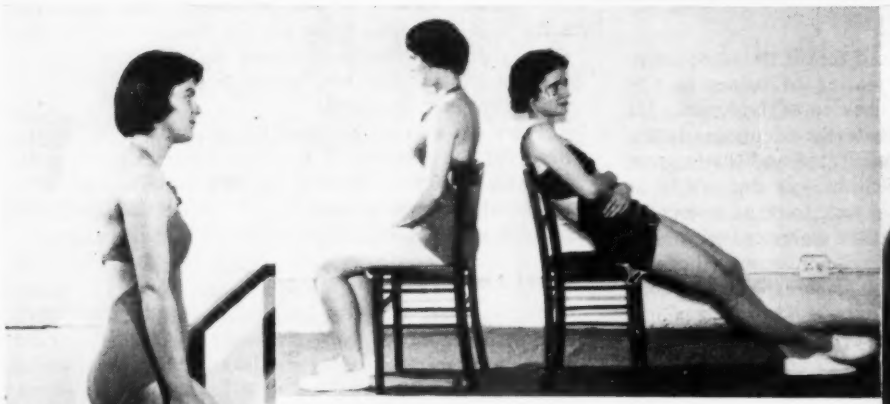


In the photograph, right, a good standing position is demonstrated by the first figure. Top arrow indicates she is standing to her full height, and to do so she must stand with weight evenly distributed on both feet.

The head is held high so that the neck is long. The shoulder blades sit well back on the chest wall. The hips are well tucked in at the back. The abdomen is well tucked in.

Notice also the legs: the extension of the knees without tension and the parallel position of the feet.

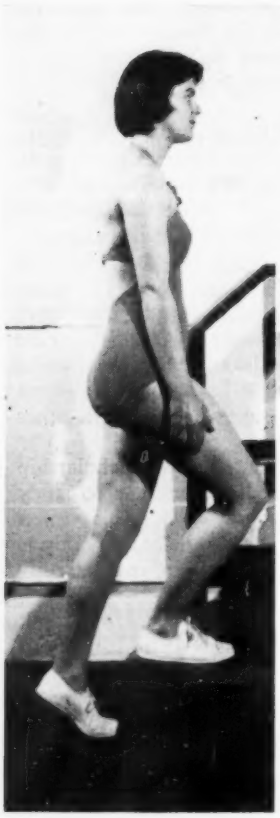
The other two figures stand in faulty positions with unequal weight throwing the body out of alignment causing aches and strains due to strain. The centre figure has too much weight on the left leg: and the right hand figure demonstrates a forward carriage of the pelvis with consequent strain on the back.



Sitting. The back and thigh of the left-hand figure are fully supported by sitting well back into the chair, and the feet are placed squarely on the floor. The position is easy.

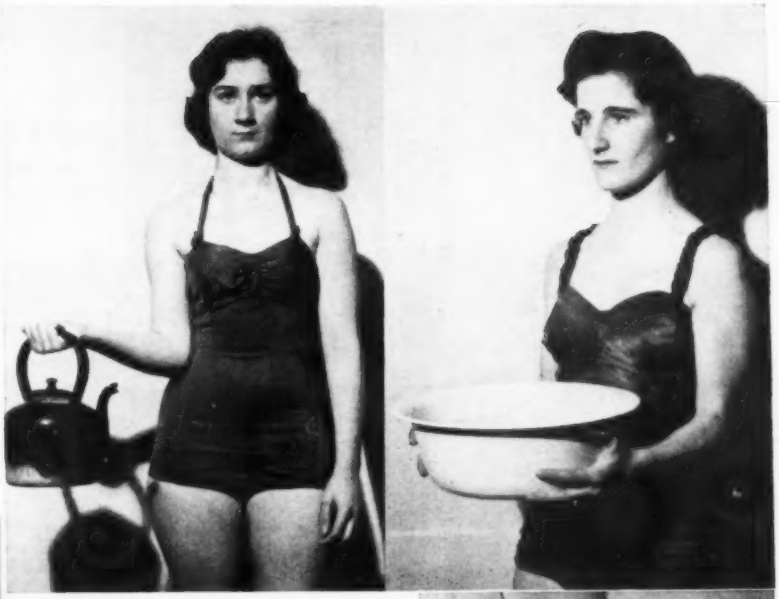
In the faulty position demonstrated on the right the back is unsupported, and this is a strain. The chest and abdomen are cramped, and this interferes with the general function of the body.

Carrying heavy bags tends to pull the body out of alignment. This model demonstrates a good posture. Her shoulders are level, and she grips the bag in such a way that there is no undue tension of the hand or wrist.



In climbing stairs, pace is important. It should be steady, and not rushed. The special points to note about this demonstration are the good carriage of the whole body: the placing of the ball of foot on the step above: and the push off from the back foot by extension of the whole leg and lift of the heel.

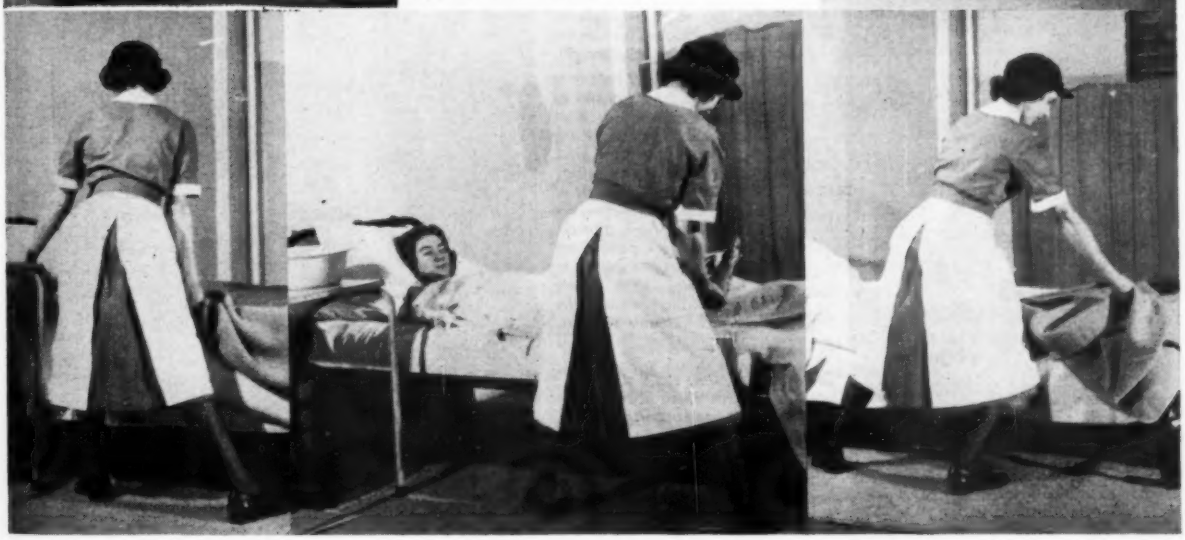
To hold a kettle the handle is held against the palm of the hand, the forearm is directed upwards, and the elbow is tucked well into the side of the body. In this way the action of pouring from the kettle is simplified.
Notice also the well tucked in elbows and the position of the hands of the model holding a bowl of water. The bowl is held close to the body.



For working at low level, whether opening a bottom drawer or making a bed, a good position of the back is maintained by fully bending the hips and knees.
Notice the position of the feet, the bend in the hips and knees and the straight back of this nurse as she tucks in the bedclothes. If stooping cannot be avoided, the nurse should make a point of standing up to her full height at regular intervals.

For perfect foot action in walking the standing leg is extended, the free leg carried forward and the heel brought in contact with the ground. Weight is then transferred by lift of heel of back foot with an extended knee, on to the forward leg. The final push forwards comes from the back foot pressing with pads of toes and allowing knee to relax. To walk properly shoes need to be flexible, as shown on the rear foot, and the importance of the height and width of heel to give firm support of instep is demonstrated on the right foot.

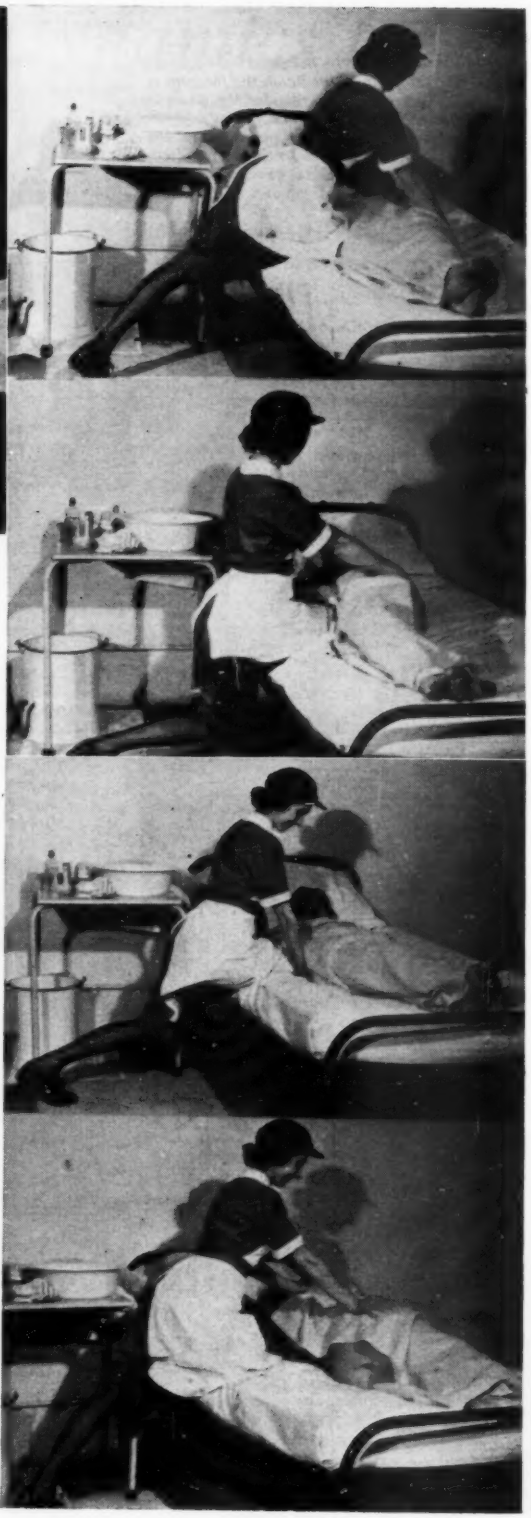
Back bending to strip beds or wash patients can be avoided by a wide stance. Notice in each of the photographs below how little the nurse's back is bent, because she bends in her hips and knees instead.



To raise patient from lying to sitting position, nurse stands with feet apart, or if the bed is low, with back knee on the bed. Near hand is placed under patient's neck, and far hand under far shoulder. The nurse's back is straight and is kept straight whilst she transfers her weight backwards to her back leg, bringing the patient up to a sitting position.

Driving. The nurse sits well back in the seat which in this case is a good one supporting the small of her back.

Sometimes it may be necessary to have a small firm cushion. Pedals should be in comfortable reach, with knees slightly bent in the resting position.



Rolling a patient. If the bed is high both feet are kept on the floor, one well behind the other and the forward leg is pressed firmly against the bed throughout the action.

For a low bed, as illustrated, one knee is placed on the bed and the weight taken on the knee. The other leg is placed well back with the foot on the floor. The back is straight.

The action of rolling is brought about by a transfer of weight to the back leg. Note that the knee of the back leg is flexed, and the back remains straight. When rolling the patient to the far side of the bed the action is reversed but the hand grip is altered. As she rolls the patient the nurse transfers her weight to the forward knee. Again throughout the operation the nurse's back remains straight.

The author is Head Almoner of Brompton Hospital, London

After-Care of Carcinoma Cases

by MARGARET S. COLTART, M.A., A.M.I.A.

CANCER patients who are cured by early treatment need much the same after-care as for other illness. I shall therefore deal only with the special needs of advanced or relapsed patients. Ironically it is those with normal family ties who present the most complicated medico-social problem. Solitary men and women are a fairly straightforward problem, though they need more befriending, because institutional care must be arranged when they become unfit to look after themselves.

The factors in lung cancer which mainly shape the pattern of after-care are the short expectation of life, the prospect of increasing pain and distress, the fear inspired by the disease and the policy of keeping the patient unaware for as long as possible that he has cancer. Temporary or permanent unfitness to work often adds worry to actual money shortage, although nowadays sick-pay for a few weeks is given in many more occupations than formerly.

Emotional Stresses

The main problem comes under two headings: ways and means, and emotional stressses endured separately by the patient and the family. Under ' ways and means ' I include all the difficulties involved in remaining at work, keeping the home going, and nursing care at home or in hospital during the terminal stage.

The emotional stresses are often extremely complex, not only because relatives know that the patient faces what is usually premature and painful death, but because the compassionate falsehood of pretending otherwise to the patient has to be kept up as long as possible. Very often a wife has told me that she dreads ' letting on ', not so much by unguarded speech as by breaking down before the patient, when worn out with anxiety or lack of rest. The strain is worst for marriage partners whose close mutual sympathy makes it impossible to hide trouble from each other. The rule of secrecy may also deprive the patient and his family of the comfort which the clergyman might give.

Wives often say, too, that they are afraid of failing to do everything possible for the patient, and that although they will manage day and night nursing while he is not too bad, they ' won't be able to watch him in pain '. Others fear the effect on their children of seeing a patient nursed at home in the terminal stage. If home care is impossible, but the patient still begs to stay, relatives often feel guilty when agreeing to hospital admission.

Social difficulties vary for patients who relapse after resection, or who live several months after thoracotomy and radiotherapy, and for those discovered only when they are at an advanced stage.

The relapsed patient with a year or less to live benefits above all by occupation. His condition may be so much improved by a convalescent holiday that he can return to work for a short time. This helps the family finances and keeps up morale. Many employers are helpful in suiting the job to the man if, with permission from the next of kin, they are told the prognosis in confidence. Convalescence is unfortunately more difficult. Provision under the National Health Service is so poor that private homes and fees usually have to be found.

When patients can no longer go out to work, some appreciate diversional therapy, but most rely on television and radio and visits from friends. This time of slowly losing ground often seems less tolerable for all concerned than even the final stage. Finance and diet become more difficult, a long-hoped-for summer holiday must be abandoned, relatives begin to worry how and when to recall sons on National Service and married daughters abroad. It sometimes helps to arrange for the patient to have two or three weeks away from home, alone if his wife needs a break, with her if she feels unable to spend apart from him any of their remaining time together.

In the terminal stage, the chief problem is usually between nursing at home and admission to hospital. If housing is poor and money short, the wife unfit or family relationships difficult, hospital care will be preferable, but if the patient takes the line " I shall never come out again " or the local chronic ward is unpopular, the family will usually carry on at any sacrifice until he is unaware of his surroundings.

' Good Appeal '

In general, lung cancer is a ' good appeal ' for obtaining money, personal service or institutional care. Neighbours, NAB officials and so on will usually stretch points as far as they possibly can, and I have known it to resolve long-standing family quarrels.

A general practitioner who is truly a ' family ' doctor is the key person who can co-ordinate care as well as give it. This can hardly be overstressed. I think also that almoners ' on call ' to GPs and in close touch with the patient's home can do a more thorough job in these cases than from within a hospital.

Practical resources are numerous, limited by lack of personnel and accommodation rather than money. Some are available in London only, some are national.

Continued on page 45

ON THE HEALTH FRONT

NEW STANDARD FOR BABY PANTS

ACKNOWLEDGING that the present Standard for baby pants does not go far enough, the British Standards Institution invites reports of experiences that will be valuable in evolving a method of testing the qualities, particularly of plastic pants which with the effects of urine and frequent washing are liable to harden and split.

The present British Standard for baby pants—which governs not only seams, elastic and press studs but also the strength of the plastic in relation to stretching and tearing, states: Any elastic to be contained in a fold; not more than eight inches without elastic; elastic must not be fully stretched when pants are open; ends of elastic must be firmly secured; reinforcement to be added where there are press studs; minimum tensile strength—2000 lb./sq. in.; minimum tear strength—250 lb./in.; minimum thickness—.004 in.

As well as complaints against hardening of plastic pants between the legs. Weakening of bindings and studs, and difficulty of erasing stains, the following comments are made: There should be ventilation holes at top. Sizes should be based on leg sizes. Many pants chafe. Elastic should be adjustable. Too many fasteners are a nuisance. Slotted tapes take days to dry. Nylon or rayon covering round the leg absorbs moisture. Press-stud types open flat for washing. Elastic legs give a better fit. A forward-facing leg is best.

The address of the British Standards Institution is: The Consumer Advisory Council, British Standards Institution, Orchard House, Orchard Street, Oxford Street, London, W.1.

HEALTH VISITORS' COMPETITION

THE Royal Society of Health is again awarding, amongst other competitions, a prize of £20 and a second prize of £7 for an essay on " How may the Health Visitor Stimulate Interest in Health Education? "

This is open only to practising and student Health Visitors, excluding administrators and teachers.

Each essay must be typewritten on foolscap paper and must not have been previously published. Essays should be limited to 4,000 words in length.

Essays must be delivered on or before 31st December, 1958, addressed to:

The Secretary of the Royal Society of Health,
90, Buckingham Palace Road,
LONDON, S.W.1.

The essay must be submitted without the name of the competitor. Each must bear a nom de plume, legibly marked on the right-hand lower angle of the first sheet. Each essay must be enclosed in an envelope, bearing the title of the competition i.e. Health Visitors Competition.

Each essay must be accompanied by a letter, in a separate sealed envelope, stating the nom de plume and the competitor's name and address, and in the case of the Health Visitors' Competition the nature of the appointment held by the essayist. The envelopes containing this information must have on the outside the name of the Competition and the same nom de plume as that attached to the essay.

Further particulars can be obtained from:

The Royal Society of Health,
90, Buckingham Palace Road,
London, S.W.1.

Among the prize-winners in last year's Royal Society of Health essay competition was Miss Mary Dickinson, S.R.N., S.C.M., Q.N. & H.V. certs., who won the first prize of £20 in the Health Visitors Competition for her essay on " The School Health Service: Possible Future Developments and the Place of the Health Visitor in any Re-organisation ". It is hoped to publish Miss Dickinson's prize-winning essay in a future issue.

HEART LORE

THE National Association for the Prevention of Tuberculosis has issued two new leaflets *What your heart does* and *Heart disease in pregnancy*—the first of a series designed for the cardiac patient, the family, and those concerned with their care. Written in simple language these pamphlets aim at reassuring the patient by giving her a better understanding of the working of the heart, so that she can help the doctor and nurse to keep her well. Explanations are given of the factors which influence the heart, the medical means of diagnosis, and the reasons why in some cases rest and dieting may be necessary.

" Patients often have groundless fears " concludes the pamphlet on *What your heart does*. "A famous actor-manager had on the wall of his office the following text: ' I have had many troubles in my life; most of them have never happened '. Patients with heart trouble should remember this. Their anxieties are usually needless and perhaps harmful ".

Copies of the pamphlets are available from the NAPT Cardiac Information Centre, Tavistock House North, Tavistock Square, London, W.C.1.

THE BATTLE AHEAD

THOSE of us who are engaged in the improvement of community health and welfare have a proud heritage. In the past hundred years the struggle started by the development of higher standards of physical environment and was followed by the scientific control of infectious diseases. In this century we have seen the development of the personal health services, and the struggle against ignorance and apathy especially in child-bearing and child-rearing.

We have now started our greatest and most difficult battle—the health and welfare problems of the individual. I do not think health and welfare are separable. The physically or mentally handicapped must be taught and helped to live with their disability as members of the community whenever possible. The sick and aged must be supported when necessary. Even the feckless must be sustained, for although it would appear that whilst we have largely succeeded in reducing to a minimum " the poor "—the " problem families " are always with us.

Whether the peoples of the future live in multi-storey flats, troglodyte burrows, or space stations, there will always be health and welfare problems, and health departments, with their tradition of service to the community, will be the best agency for the provision of a comprehensive means of help to the public.

—Andrew B. Semple, V.R.D., M.D., D.P.H., F.R.S.H., Medical Officer of Health, Liverpool; Professor of Public Health, University of Liverpool; at a sessional meeting of the Royal Society of Health.

COMMODE CHAIR

A COMBINED commode chair has been designed by Mr. McKim McCullagh, F.R.C.S., F.R.C.O.G., as an aid to nursing and to the comfort and care of bed patients. Writing in the British Medical Journal, Mr. McCullagh describes the chair as a tubular tub chair with a silent wheel on each front leg, a metal loop handle on the top of the back of the chair, with a seat with metal holding-hooks, which can be lifted off, exposing a "perfection" bedpan in a rubber-covered metal cradle. This bedpan is so well hidden that visitors do not object to using the chair as a seat. The chair moves on its two front wheels, when it is eased off the ground by lifting the back of the chair with the loop handle. It is readily wheeled to the bedside and put in position. The seat is lifted and the patients are helped out on to the chair on one or two occasions only; they do their own toilet and clamber back into bed. The nurse comes back at her own convenience, replaces the lid, and wheels the chair off to the sluice-room—a much more dignified procedure than carrying bedpans face-high. In the sluice-room the bedpan is emptied, washed and sterilised, and a clean bedpan is placed in the chair.

The chair may be purchased from Messrs. Chas. F. Thackray, Ltd., Park Street, Leeds, or from their London branch in Welbeck Street, W.1.

After-Care of Carcinoma

Contd. from p. 43

For home care, there are the district nursing associations, home helps (including some able to ' sit-in ' at night), invalid meals service, and provision of additional beds and bedding. These come under the statutory and permissive powers of the local health authority.

Additional nursing help is given through the *Marie Curie Memorial Fund* which pays a private night nurse supplied by the District Nursing Association. The Fund has also started a service of night nurses on call for urgent visits in a limited area of London. The *British Red Cross Society* everywhere lends nursing equipment.

In London there are four hospitals for terminal care, three run by religious orders. All are free, and stipulate only that the patient is not expected to live more than six months. The atmosphere is kept as much as possible like that of any general hospital but some have better amenities in the form of small wards, television and more flexible visiting hours. The *Marie Curie Fund* also runs five homes for terminal and pre-terminal care, in London, Devon, Scotland and Newcastle-upon-Tyne, but waiting lists are long.

In financial difficulty, the *National Assistance Board* will make extra grants for special nourishment and laundry, but the most generous help comes from *The National Society for Cancer Relief.* I do not remember this body ever refusing an application. Weekly grants of about 10s. are made for comforts, invalid foods and extra fuel, and larger sums for private convalescent and nursing home fees. A big range of trade and Services' charities may also be called on for the same needs. So resources of help are good, but highly individual work is needed in using them to satisfy patients and relatives that everything possible is being done. For instance, if a man living in Battersea needs a terminal care home I suggest to the family that St. Luke's, Bayswater, will be a less revealing choice than the Hostel of God at Clapham, especially as it can be called a branch of St. Mary's Hospital, Paddington.

To sum up—good after-care depends on knowing the patient and family well, and giving steady personal support throughout, especially in the strains imposed by the ' conspiracy of silence '. It means planning ahead to act quickly in a crisis, and working always in close co-operation with the doctor in charge.

I should like diffidently to make two suggestions. First, that many GPs would welcome more instruction about after-care facilities. Secondly that, with increasing public knowledge about lung cancer, more patients now may guess their diagnosis and might find relief in talking with their doctors. If it comes to the point of patients keeping silence to spare the feelings of the staff who look after them we shall have to find some answer to this paradox of the double bluff!

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For Nurses in Need

THE Nation's Fund for Nurses was instituted in 1917 with the dual purpose of providing a Benevolent Fund for Nurses and endowing the College of Nursing. Numerous entertainments, concerts and balls, were successfully organised by the leading actresses and prominent people of the day. By the end of 1919, £148,915 had been collected under the guidance of Dame May Whitty as Chairman, Miss Lilian Braithwaite, Honorary Secretary, and Viscountess Cowdray as Honorary Treasurer, whose personal gifts ensured the great success of the venture.

All fully qualified British Nurses of limited means are eligible to apply. Since the inception of the Fund thousands of members of the Nursing profession have been helped with single gifts, continuous grants, annuities and special pensions. Nurses permanently disabled by illness, accident or old age have been assisted to find suitable Homes. Unfortunately the latter service is becoming very difficult to accomplish owing to the lack of suitable Homes for the elderly.

Some of the applicants are found to be eligible for other Benevolent Funds and they are put in touch with these Organisations. The kind help and courtesy received from these Societies is greatly appreciated.

The College of Nursing, now the Royal College of Nursing, is a separate organisation from the Benevolent Fund but enjoys representation on the Council, Board and Relief Committee of the Nation's Fund for Nurses.

The Benevolent Fund is administered by the Relief Committee appointed by the Board of Management of the Nation's Fund for Nurses.

The Funds used for this purpose are derived from investments, general donations, donations from special Trusts, legacies and The Royal College of Nursing Appeal for the Nation's Fund for Nurses. The latter appears weekly in the *Nursing Times*.

Several other Funds are administered by the Relief Committee viz.:

The Special Funds

Many gifts and legacies received in the past from sympathetic and generous donors have made it possible for the Relief Committee to allocate a number of pensions or annuities ranging from 5s. 6d. to £1 weekly in the name of the donor. .

Dinah Dawson Trust

For many years the Board of Management of the Nation's Fund for Nurses has received with gratitude a generous annual donation from Messrs. John Brodie & Sons, W.S. under Miss Dinah Margaret Dawson's Trust for the benefit of nurses domiciled in Edinburgh, Glasgow and Falkirk.

Sir James Knott Charities Trust

The above-mentioned Trust also very kindly sends a special annual donation of £100 for nurses residing in the Tyneside area.

Dudley Struben Memorial Fund

During 1929 the Nation's Fund was presented with a small cottage on the understanding that the property should be used as a home for a retired nurse, or nurses, when the present tenant (a retired nurse) no longer requires it.

The Queen Alexandra Relief Fund for War Nurses

In 1922 the Nation's Fund was asked to take over the administration of this Fund; the assets to be used solely for ex-service Nurses. There are usually ten annuitants who benefit under the scheme.

The Church Nurses' Guild

The administration of this Fund is carried out by the Committee of the Nation's Fund in accordance with a Scheme of the Charity Commission sealed on the 23rd of February, 1923. The income provides a grant towards the cost of a holiday or fees in a Convalescent Home for a nurse who must be a member of the Church of England.

The Nurses' Benefit Fund for East Lancashire

The members for the time being of the Board of Management of the Nation's Fund for Nurses are the Trustees of the Nurses Benefit Fund for East Lancashire and have to administer the Fund in accordance with a Scheme sealed by the Charity Commission dated 17th April, 1953.

The " Nursing Mirror " Nurses and Midwives' Fund

This Fund which was founded as the Elderly Nurses' Fund is for Nurses who are ineligible for the Nation's Fund for Nurses, and exists to assist Nurses and Midwives who in the opinion of the administrators of the Fund merit consideration and sympathy in poverty, disablement, illness or old age by reason of their record of practical service in the field of nursing. Any help given is not confined to nurses and midwives who have a registered qualification. An appeal for funds on their behalf appears regularly in the *Nursing Mirror* and donations should be sent to Miss J. Elise Gordon, O.B.E., M.A., Editor of the *Nursing Mirror*, Dorset House, Stamford Street, London, S.E.1. The collections are then remitted to the Nation's Fund for Nurses for allocation.

The Nation's Tribute to Nurses

The result of collections made in Ireland under the original appeal of the Nation's Fund for Nurses, is administered in Eire and its Committee has representation on the Council of the Nation's Fund for Nurses.

The Edith Cavell Homes of Rest for Nurses

An entirely separate organisation from the Nation's Fund for Nurses but shares the same office and contributes towards administrative expenses. These Homes provide restful holidays for practising nurses of limited means.

From the Annual Report of the Nation's Fund for Nurses, 21 Cavendish Square, London, W.1

NURSING BOOKSHELF

THIS month I have read two books with particular interest because they deal with subjects in the news. One is on adoption and the Children's Bill which had its second reading in the House of Lords, on 11th April. The other concerns mental health and the Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency which has aroused great public interest and is likely to lead to changes in legislation.

First, then, **The Adopted Child by Mary Ellison** (Gollancz 16*s*.).

When this book was brought to my notice I thought it was a pity that it should appear now when we are probably on the eve of changes in the law relating to adoption. However, on reading it, I feel it is a book to be recommended to health visitors and social workers and all, in fact, who are concerned with the welfare of children.

The early chapters deal with the sorry plight of children in past centuries, and if many of us think that the pendulum has swung too far in the opposite direction today, as the author remarks:

"The twentieth century . . . appears to have been staging a large and generous act of compensation to the deprived child for past neglect."

One chapter sets out in a clear, readable manner the details of the Adoption Act, 1950; and other chapters deal with the adopting parents—the child—and the mother who places her child for adoption.

Most children who are placed for adoption are the children of unmarried mothers, and the author writes with a sympathetic understanding of the many problems to be dealt with in this situation. The final chapter is devoted to consideration of the Hurst Report.

Mary Ellison describes the Adoption Act of 1950 as 'a noble measure that has brought happiness to thousands', and concludes her book by saying 'Certain clauses of the Act may require expansion or modification as the years go by, but its balance and spirit will surely stand the test of time'.

Those who read this book should be very interested in watching the progress of future legislation relating to the care of the deprived child.

The other book is **A Mental Health Handbook by Ian Skottowe** (Edward Arnold, 21*s*.).

For a long time now there has been a very real need for a book such as this in the library of the Health Visitors' Course. I am glad, therefore, that it has been written and will certainly add it to my library list. The book begins with a brief review of the Mental Health Services under the Lunacy Act 1890, Mental Deficiency Act 1913, Mental Treatment Act 1930, to the present day situation as affected by the National Health Service Act, 1946.

Public health workers today are constantly reminded that the total care of the individual—and the family—must include attention to the social and mental well-being as well as the physical state. Many, especially those who have just come from the field of curative medicine, must be aware of gaps in their knowledge, and perhaps feel inadequate to carry this out successfully. Study of the further chapters in this book under the headings 'What is Mental Health?, Personality and Constitution, Natural Experience and Social Culture, The Varieties of Mental Ill Health' will be found most helpful.

In chapter 6 the author reminds us that many disturbances of mental health come to light through the personal, family and social problems that they cause. Thus, district nurses, midwives and health visitors may be the first to discern these disturbances. We must not be too ready to attribute every social breakdown or problem to 'mental ill-health' but it is essential that we are always conscious of the fact that there may be some relationship. Special situations are cited where this is likely to apply e.g., problem families, neglected children, and maladjusted school children.

When writing of social workers and their training, reference is made to the fact that in dealing with some cases today a considerable number of social workers may be needed, and the wisdom of this suggestion is doubted. It is maintained that a larger number of people (e.g. health visitors or public health nurses) should know more about mental health and direct some of their activities specifically towards it in the course of their ordinary work. A very good reason for reading this book, surely!

I have one small criticism to make, although on re-reading this book at more leisure I may find that it is unjustified. I could have wished that there had been more reference to mental deficiency and its consequences. The presence of a mentally defective child in the family can raise many problems. The health visitor is often asked for help and advice and very often it is difficult to supply the right answer.

H.H.C.

Psychoprophylactic Preparation for Painless Childbirth by Isidore Bonstein, M.D. (Heinemann, 12s. 6d.).

Many nurses and midwives have some knowledge of the modern methods of natural childbirth.

In "Psychoprophylactic Preparation for Painless Childbirth", Dr. Bonstein begins by explaining how the brain is stimulated to feel pain and other sensations, and how by correct teaching during pregnancy, a mother can realise childbirth as a pleasant sensation instead of a painful ordeal. It is pointed out that for painless childbirth team work is necessary, and not only should the mother be prepared, but the doctors and nurses and the patient's family should have the right outlook toward painless childbirth.

In one chapter is set out a programme of a course of eight lectures given at the Dr. Lamaze Maternity Hospital in Paris, which gives the aims of each lecture which include an introduction to the mother, also lectures on the physiology of respiration, a study of muscular relaxation, the mechanism of labour and how the mother should behave during labour. Later in the book a fuller text is given of the eight lectures used for mothers at Cleveland, Ohio.

The book suggests that Dr. Bonstein has only hospital delivery in mind, with very tranquil conditions, and a staff of helpers for each patient, at least during the actual delivery.

The book contains photographs of patients in labour and during the actual delivery of the child, in which the mothers look as if the experience is a happy one.

The book concludes with reports written by mothers who delivered their babies successfully by the method taught by Dr. Bonstein.

R.A.B.

Questions from readers on points of education and practice in public health nursing services, for discussion by the Institute's Education Officer on this page, are warmly invited

Queen's Health Visitor Training Centres

THE Queen's Institute has many educational activities, all of them concerned with the training and preparation of the public health nurse, whether she wishes to work as a full-time district nurse, a full-time midwife or a full-time health visitor, or whether she wishes to undertake generalised work combining these duties.

Each year, over 700 nurses take the district nurse training at one of the 62 training centres approved by the Queen's Institute in the British Isles; over 350 take Part II midwifery training at one of the Queen's midwifery schools, and another 50–60 take the health visitor training at one of the two centres organised by the Queen's Institute since 1948.

Immediately after the last war, the existing health visitor training centres were unable to cater for all the students who applied for training, and Queen's nurses, among others, were finding it very difficult to obtain vacancies.

First Institute centre

In 1948, the Queen's Institute opened their first health visitor training centre at Brighton and followed with a second in 1949 at Bolton. At both these centres students may take the complete health visitor training, which until 1951 was a full-time six months course but since then has been a nine months syllabus. Some students who are S.R.N. and S.C.M., elect to take a 12 months course which includes district nurse training as well, and is intended to prepare the student for generalised duties, e.g. district nursing, midwifery and health visiting.

Thus there is a very good mixture of students at these courses. It is felt that it is most desirable for the whole-time health visitor and the generalised public health nurse to mix freely together during their early days.

Both the health visitor centres grew up to meet actual needs. The Brighton course was established in a town surrounded by rural areas where generalised duties are practised in very good conditions. Bolton is an industrial town in Lancashire surrounded by every type of public health service and practical experience for the students is found readily.

Another reason for establishing these centres at Bolton and Brighton was the readiness with which the education authorities in these towns co-operated. They placed adequate accommodation in their technical colleges at our disposal, providing classrooms and equipment for showing films for our use. They also had experienced lecturers on their staff who were well qualified to give certain lectures, for example, the principles of teaching.

At each centre the Queen's Institute has appointed a full-time Organising Tutor who is in charge of the course. At present the tutors are Miss H. H. Conner, S.R.N., S.C.M., Queen's Nurse and H.V.; and Miss M. B. Nicoll, S.R.N., S.C.M., Queen's Nurse and H.V. Both are qualified public health tutors. They are responsible for inviting all the many specialists required to take part in the teaching programme, for drawing up the time table, for giving tutorials and for the day to day management and general care of the students.

Both courses are approved by the Ministry of Health and cover the syllabus for the Health Visitors Examination of the Royal Society of Health. The nine months of the course are quite strenuous but are full of exciting and intensely interesting new subjects. The students' thoughts are directed constantly to the ways in which illnesses may be prevented. They are taught to consider the whole of an individual's personality—his physical, mental and social needs, and to think of him as a member of a family and of his place in the community.

Among the important new subjects taught are the physical, mental and psychological development of children, the principles and practice of teaching, and the great importance of mental health. The teaching is balanced fairly evenly between theoretical and practical work.

The practical training includes observing the work of experienced health visitors when they are visiting homes, or working in clinics or schools, or teaching various groups. Each student spends some time with a full-time health visitor and some with a generalised worker. All students are given opportunities of seeing the work of various kinds of social workers, and of other members of the health team, and each student is given practice in group teaching which gives her confidence to face all kinds of audiences.

The health visitor's training has changed greatly during these ten years to meet the needs of the time. For many years the health visitor concentrated on improving the physical and material conditions of mothers and children under five years of age, and also of school children. Now the National Health Service demands that the health visitor widen her interests and care for the whole family, young and old alike.

Modern knowledge also teaches us that satisfactory physical and environmental conditions alone are not sufficient for good health. The mental and psychological side of life needs equal attention. So the health visitor's curriculum has grown to meet the needs, and the tutors will see that it keeps pace with modern scientific progress.

Each centre can take a maximum of 30 students, and for many years the Queen's Institute centres have trained the second largest number of health visitors trained in this country. The students come from all parts of the British Isles and from countries overseas. Most of them receive scholarships from the local health authorities—or from the country of their origin.

Consolidating period

After qualifying as health visitors these students are expected to work for the sponsoring authority for a period of approximately two years. This is an excellent arrangement, for training only gives a student the essentials and the two years' practice are a consolidating period, during which the theoretical knowledge is tested and used.

The courses of health visiting and district nursing are proving to be of special value to nurses from other countries or to those from this country who wish to pioneer public health nursing in newly developing countries in Africa and the Far East.

As far as possible within the requirements of the Royal Society of Health and the time available, we aim at giving a wide outlook on basic health needs.

Queen's Nurses Personnel changes 1st to 31st March, 1958

APPOINTMENTS

Superintendents, etc.

Allinson, Laura, Leicestershire (County Superintendent).
Davies, Marion, West Sussex (Supt. Nursing Officer).
Hart, Joan M., Metropolitan D. N. A. (Assistant Superintendent).
Rothwell, Mary E., Hammersmith (Assistant Superintendent).
Sykes, Mary, Darlington (Assistant Superintendent).
Wright, Silvia M., Leicestershire (Deputy Superintendent).

Nurses

Barney, Ena L., Warwickshire.
Bedding, Doris, Colchester, Essex.
Callaghan, Margaret (Mrs.), Birmingham.
Chisholm, Jean R., West Riding.
Chorlton, Pamela, Caernarvonshire.
Clark, Kathleen M., West Sussex.
Cook, Lucile (Mrs.), Gosport, Hants.
Cunningham, June (Mrs.), Reading.
Cunningham, Alistair, Reading.
Dwyer, Mary Anne, Metropolitan.
Ferguson, Hilary M., Cheshire.
Follett, Patricia, Reading.
Gwilliam, Rosamund, Gloucestershire.
Hamilton, Mary (Mrs.), Woolwich & Plumstead.
Harris, Mary E., Caernarvonshire.
Hill, Charlotte (Mrs.), Leicestershire.
Holt, Ruth Cawford, Metropolitan.
Hunter, Phyllis E., Antrim.
Hurdman, Evelyn M., Fulham D. N. A.
Joslin, Muriel (Mrs.), Bedfordshire.
Lang, Annie Louise, Torquay.
Moody, Jane E., Caernarvonshire.
Onyon, Mary Florence, Cornwall.
Owens, Sheila M., Pembrokeshire.
Parry, Mary, Devon.
Pearce, Iris G., Kilburn & W. Hampstead.
Rantzau, Mary (Mrs.), West Sussex.
Royle, Pamela, Shropshire.
Stubbs, Dorothy Mary, Somerset.
Thomas, Ann, Radnorshire.
Trasler, Beryl, Hampshire.
Wynne, Elizabeth, Northampton.

RESIGNATIONS

Anderson, Eileen (Mrs.), Oxford—Domestic reasons.
Anstock, Peggy (Mrs.), W. Riding—Domestic reasons.
Archer, Howard Mr., Essex—New work.
Barrett, Kathleen (Mrs.), Essex—Domestic reasons.
Bayley, Paula (Mrs.), Manchester—Domestic reasons.
Beattie, Margaret (Mrs.), Hammersmith—Return to Nyasaland.
Boyd, Anne J. (Mrs.), Belfast—Domestic.
Butler, Dorothy (Mrs.), W. Riding—Other work.
Carty, Winifred M. (Mrs.), Manchester—Domestic.
Clarke, Maureen E., Anglesey—Hospital abroad.
Conyngham, Mary (Mrs.), Southport—Domestic.
Cushen, Josephine, Berkshire—Post abroad.
Daniel, Una A., Berkshire—Marriage.
Davey, Olive, Leicester—Domestic.
Denstone, Rose M. (Mrs.), Birmingham—Leaving district.
Drew, Ann, Cheltenham—Family reasons.
Dunn, Edith, Breconshire—Health reasons.
Evans, Vera, Salford—Probation Officer Course.
Fagan, Gladys M., Westmorland—Retirement.
Fraser, Heather M., Nottingham—Domestic reasons.
Garrod, Audrey, Essex—H.V. training.
Greaves, Teresa (Mrs.), Blackburn—Domestic reasons.
Goodridge, Joan, Exeter—Work in Rhodesia.
Hacker, Margaret, Somerset—Domestic reasons.
Haines, Helen (Mrs.), Birmingham—Leaving district.
Harvey, Rachel M. (Mrs.), Somerset—Marriage.
Hay, Valerie (Mrs.), Rochdale—Hosp. post.
Hayler, Guy R. (Mr.), Brighton—Mental nurse training.
Heath, Joyce, Somerset—Domestic reasons.
Hill, Phyllis M., Metropolitan—Full time H.V.
Hodgson, Mary, Leeds—Midwifery training.
Holloway, Frances, Cornwall—Other work.
Holt, Ruth C., Bath—Voluntary.
Hopewell, Nelly I., Nottingham—Midwifery training.
Hutchings, Noreen V., North London—Private nursing.
Keeble, Charis M., West Sussex—H. V. Training.
Keelan, Audrey, Nottingham—Going abroad.
Keep, Ethel G. (Mrs.), Cambs.—Health.
Keggan, Catherine (Mrs.), Salford—Domestic reasons.
Kent, Doris, Somerset—Post in Shropshire.
Maltby, Margaret, Essex—Hospital post.
Marriott, Olive R., W. Riding—Health.
McLennan, Gladys, Warwickshire—Post in New Zealand.
McSweeney, Deborah, Fulham—Marriage.
Mitchinson, Florence (Mrs.), Middlesbrough—Health.
Mythew, Johanna P., Woolwich—Domestic reasons.
Nason, Irene, East Sussex—Post under SSAFA in Malaya.
O'Mahony, Anna M., Liverpool—Marriage.
Padwick, Nita (Mrs.), Plymouth—Domestic reasons.
Poole, Margaret, Hampshire—Domestic reasons.
Prior, Margaret, E. Middlesex—Retirement.
Rawlings, Sheila M., East London—Work for Grenfell Mission.
Reilly, Mary, Coventry—Hospital post.
Riley, Florence (Mrs.), Salford—Domestic reasons.
Rizvi, Najma, Essex—Returning to Pakistan.
Roberts, Heulwen, Caernarvonshire—Marriage.
Roberts, Sarah E., Caernarvonshire—Retirement.
Robinson, Rose (Mrs.), Nottingham—Domestic reasons.
Rogers, Ellen R. (Mrs.), Essex—Voluntary.
Saw, Marjorie, Essex—Going to Australia.
Simpson, Mary, East Riding—Going to Australia.
Shave, Beryl (Mrs.), Somerset—Marriage.
Snell, Gladys, Devonshire—Missionary work.
Spark, Joan, Middlesbrough—Health.
Spicer, Dorothy, Croydon—Health.
Spooner, Dorothy, East Sussex—Other work.
Standen, Patricia C., Reading—Other work.
Stiessel, Eleanor (Mrs.), West Sussex—Domestic reasons.
Thomas, Irene (Mrs.), West Riding.
Wenborn, Joan, Breconshire—H. V. Tutor Training Course.
Wilson, Margaret, Leeds City—New post.
Wolton, Rosamund, Exeter—Return to Rhodesia.
Wood, Margaret, Bristol—Midwifery Training.
Wood, Margaret, Devonshire—New post.
Wood, Millicent, Salford—Post in Australia.
Wyatt, Gladys (Mrs.), Surrey—Personal.
Zivanovic, Vojislav (Mr.), Essex—Probation Officer training.

STAINED GLASS WINDOW DESIGN COMPETITION

Miss B. K. P. Brown, S.R.N., S.C.M., Queen's nurse at Caunton, Newark, Nottinghamshire, was first prize-winner in this competition, which was for a suggestion for two stained glass panels in the window which is being contributed to the new Guildford Cathedral by the nursing profession. The large number of entries were judged by Sir Edward Maufe, R.A., Architect of the Cathedral, and Dame Elizabeth Cockayne, D.B.E., Chief Nursing Officer, Ministry of Health.

REJOINERS

Beckett, Mildred May (Mrs.), Liverpool.
Beech, Audrey Hariett D. (Mrs.), Liverpool.
Butler, Olive May (Mrs.), Buckinghamshire.
Callaghan, Margaret J. (Mrs.), Birmingham.
Chisholm, Jean R., West Riding.
Durley, Ivy Constance, Hampshire.
Fuller, Daisy Lily (Mrs.), Norfolk.
Goodison, Millicent M. O., Lancs. Div. 2.
Greggs, Mary Winifred, Gloucestershire.
Hamilton, Mary (Mrs.), Woolwich.
Hatton, Mary Ann (Mrs.), Isle of Ely.
Hawes, Mary Veronica, Hampshire.
Hulks, Ruth Phyllis, Kilburn & W. Hampstead.
Humphrey, Margaret H. (Mrs.), Nottingham City.
Inglefield, Hazel M., East London.
Jones, Bessie (Mrs.), East Riding.
Jorgensen, Muriel (Mrs.), Bristol.
Kelly, Kathleen M., Kent.
Knowles, Elsie, Huddersfield.
Lang, Annie L., Torquay.
Rendell, Dolly M. (Mrs.), Blackburn.

Scottish Branch

APPOINTMENTS

Nurses

Chalmers, G. E., Dundee.
Clark, D. J., Durris.
Cox, J. S. P., Monifieth.
Forbes, A. M. S., Arbuthnott.
Foster, M. A. H., Granton.
Gillies, A. R., Fortrose.
Henderson, Mary, Alloa.
Jackson, A. D., Hawick.
Jamieson, M., Prestwick.
Macrae, K., Alness.
MacKenzie, C. G., Conon-Bridge.
MacLeod, H. M., Clydebank.
MacVicar, J. C., Clydeside.
Park, I., Danderhall.
Radcliffe, M. E., Kilchoman.
Ross, Irene, Tillicoultry.
Smith, D. H., Forres.
Smith, M. J., Cromarty.
Todd, E., Lochgelly.
Wallace, B. B., Strontian.

REJOINER

Fraser, Mrs. R., Achiltibuie.

RESIGNATIONS

Allan, Caroline E. C., Lossiemouth—Marriage.
Atkinson, Jemima Jack, Shieldhill—Other Work.
Bennie, Agnes McL., Blantyre—Retired.
Carrall, Martha, Kilmarnock—Other Work.
Coltart, Margt. Hope, Ayr—Marriage.
Cook, Annie Proctor, Denbeath—Marriage.
Crighton, Eliz. Jean, Ayrshire—Other Work.
Cruickshanks, Annie D., Durris—Marriage.
Ferrier, Alma, Monifieth—Work Abroad.
Hourston, Kathleen, Kirkwall—Marriage.
Lavin, Mary Teresa, Glasgow (Govan)—Marriage.
Lawson, Alexander, Edinburgh—Other Work.
MacKillop, Margt. C., Campbeltown—Other Work.
MacKintosh, Annie, Danderhall—Marriage.
MacRae, Mary, Campbeltown—Other Work.
Ross, Jean H. H., Clydebank—Other Work.

Miss Charlotte Watt Duncan

The untimely death on 20th March, 1958 of Miss Charlotte Watt Duncan, through a motor car accident, is recorded with deep regret.

Miss Duncan had been attached to the Scottish Branch of the Institute since June, 1942, and had given her entire service to the Dundee Home Nursing Service. Her bright, cheerful personality endeared her to those with whom she came in contact and she was much beloved by her patients and colleagues. Miss Duncan was 44 years of age.

Inner Tube Tourniquet

A cry of " Oh, nurse, could you help us, someone is bleeding badly in the butcher's shop " stopped Cynthia Young a student district nurse in Nottingham, as she was cycling home for lunch. At first the amount of chaos and confusion and blood that greeted her made her think someone was trying to prevent an attempted suicide. However, what had happened was that the chopper had slipped from its normal resting place and severed the artery in a butcher's leg.

Hastily glancing round, Nurse Young saw an inner cycle tube and with this she quickly brought the haemorrhage under control.

Admitted to hospital for treatment, the patient was told that the timely care with the inner tube had probably prevented amputation of the leg. Within a few days he returned home to the care of the same district nurse, who had meanwhile found what she regarded as a minor interruption of her normal day's work, widely reported in press and radio.

For the time being, she comments, Nurse Young seems to be stuck with the label of " the nurse who used an inner tube to save the butcher's leg."

HORSE AND COW

Mrs. Margaret Goolden, S.R.N., S.C.M., formerly Queen's nurse at Toddington, Bedfordshire, has with a partner opened an old Devon farmhouse set in seven-and-a-half acres of land, as a guest house at Croyde, North Devon.

" We grow all our own vegetables and most of our fruit. We have our own attested cow, so that we always have a good supply of milk and cream in the season. The cow is such a success that we are thinking of buying another one. We also have a very large horse. Her name is Julie, and we care for her for her owner, who lives in London. She gives our children a lot of joy. She is very quiet and patient with them.

" Julie absolutely adores the cow and because of this love, I am at the moment languishing in bed with a badly bashed knee. I had brought the cow out of the field for the inspector from the Ministry of Agriculture to see. Julie thought she was absent for too long, and so took a flying leap over a tall embankment (and nearly killed herself) to be with her dear friend. They then both started up the lane for goodness knows where. I pelted back to the house to get the car to head them off, caught my foot on a rock submerged in mud, and fell headlong. When all the excitement was over, I became very much aware of a sprained wrist, a chunk out of the palm of my hand, and a knee like a football. But I am recovering rapidly.

"At the moment we have 500 chickens, including 50 laying hens. They give us what seems to be an unlimited supply of eggs and really beautiful birds for the table. What we can't eat, we sell.

" The best months for a holiday in Devon are May, June and October—or from Easter, really. The weather is so much better than in August, when it is inclined to rain. My partner Mrs. Boutwood and I extend a very warm welcome to all nurses. We like having them better than any other kind of guest, and we make a point of giving them breakfast in bed if they wish it ".

QUEEN'S INSTITUTE BENEVOLENT FUNDS

The Queen's Institute administers a number of Benevolent Funds for elderly, sick and retired Queen's and non-Queen's district nurses and midwives, and for former members of its staff.

Information regarding the various funds may be obtained from the General Secretary, Queen's Institute of District Nursing, 57 Lower Belgrave Street, London, S.W.1.

Tanganyika Pioneer

Miss A. Large, S.R.N., S.C.M., H.V. and Q.I.D.N. certs., formerly Nursing Superintendent, St. Olave's District Nursing Association, has been appointed to pioneer a district nursing service in Tanganyika. Miss Large left by air for Tanganyika on Thursday, 17th April. She has been seconded by the Queen's Institute, who will be responsible for her salary, superannuation and travelling expenses for the first six months.

It is planned to start the service in Dar-es-Salaam, and two Queen's trained Tanganyikan Nurses have already been appointed to the staff. The chairman of the district nursing committee is Lady Twining, wife of the Governor, on whose instigation the district nursing service was inaugurated.

Nursing Mirror photograph

Miss Large is seen off at the Air Terminal by members of Headquarters staff

A MIDWIFE IN ALBERTA

THE only midwives in Canada are strangers from other countries. There is no such thing as a midwife trained in this country. All deliveries are undertaken by the obstetricians with a little assistance from the patient! To any midwife who loves her work it is heartbreaking not to have a delivery now and then. As for ante-natal care, well, I may have been unlucky but I haven't seen any.

Nursing in Canada is approached from an entirely different angle, and the student's training is far more removed from the patient than I would have thought possible. Wonderful laboratory tests are performed on the patients when they enter hospital, but it is a remote way of nursing compared with the way I was trained—the patient came first, the tests afterwards. Not that there is any unkindness to the patients: they are just treated as cases, a thing we were never allowed to do.

The hospitals are very up to date and have every modern convenience, and the average nurse has no manual labour at all. There are so many technicians over here that plain bedside nursing is apt to be overlooked.

I enquired about public health work a little while ago as I thought my Queen's Training would be an asset in that field of work, as well as my three years experience on a district. Imagine my surprise when I was told that I had to have either a B.Sc. degree or a Public Health certificate to enable me to help in the school clinics!

The Public Health Nurses in the rural districts have large areas to cover and do a great deal of school work.

I believe there are district nurses in the North of the Province who go out in all weathers with dog teams where necessary. Their life must be exciting and full.

Coming to Canada has been a great experience, but for a fuller and deeper satisfaction in one's work, give me a British district nurse's life every time.

Why are the Canadian papers and the British nursing papers always asking for British trained nurses? Because they know we are trained to work for the good of the patient at all times and if necessary at all hours.

This eight hour shift system goes against the grain. The nurses become too much like clock-watchers, ready to rush off duty the minute the time is up.

In contrast the nurses' uniform is most attractive. Their white dresses are made of the latest nylons and terylenes on the market and of the latest styles. White shoes and stockings are very nice, too, compared with the black so beloved in the British hospitals.

The heat of the hospitals is one thing I was not prepared for, and at times it is overwhelming and very hard on the feet.

Everything is on such a vast scale here that description is impossible. On the prairies there are no trees to break the view, and nothing to see but flat land right to the horizon. For the last few months it has been covered with snow, great drifts like banks of cotton wool. In the summer the land is burnt up by the sun, and aptly called the "Bald Headed Prairie". In contrast the Rockie Mountains sprawling behind Calgary, make a magnificent sight that fills the eye with wonder.

Constance A. Russell

NOTTINGHAM RENDEZVOUS

THE Joint Sub-Committee of Counties & County Boroughs of the Queen's Institute is a committee of representatives of the local authorities in membership with, and the district nursing associations in affiliation to, the Institute —a committee representing those directly responsible for the district nursing service in the counties and county boroughs of England & Wales. Three meetings are held each year, one of which takes place outside London.

This year the meeting was at Nottingham where members were guests of the Mayor and Corporation at lunch. They also visited Nuffield House, an occupation centre for the elderly where elderly people, many of whom are or have been mentally ill, go each day to occupy their time on handiwork, which is sold from time to time at a charge to cover the cost of the materials. Buses bring these old people to and from the centre and a meal is supplied cheaply.

It was pointed out that one of the unexpected advantages resulting from the establishment of this centre was the benefit to the family, to have some free time when the elderly relative was being looked after elsewhere.

The committee meeting was held in the old Jury Room of the Guildhall and representatives of the local health department and the Nottinghamshire Nursing Federation were present.

Grateful thanks are due to Dr. Dodd, Medical Officer of Health, Nottingham, and Dr. Patricia Shaw, a member of the Joint Sub-Committee, and to their staff for the excellent arrangements, and to the Lord Mayor and Corporation for their very generous hospitality.

CLASSIFIED ADVERTISEMENTS

Advertisements for this section can be received up to first post on the 2nd of the month for publication on the 10th. They should be sent direct to: District Nursing, 57 Lower Belgrave Street, London, S.W.1. Telephone Sloane 0355.
Rates: Personal, 2½d. per word (minimum 12 words, 2s. 6d.): all other sections, 3d. per word (minimum, 12 words 3s.)
Displayed Setting: 17s. 6d. per single column inch.

APPOINTMENTS

CITY OF BATH

District Nurse

District Nurse required for general work with the Bath District Nursing Association. Queen's training an advantage.

Whitley Council Scales for Nurses and Midwives. Car allowance.

Apply to the Medical Officer of Health, Sawclose, Bath.

JARED E. DIXON
Town Clerk

Guildhall,
Bath

CORPORATION OF THE CITY OF ABERDEEN
HEALTH AND WELFARE DEPARTMENT

Centre Superintendent Health Visitor

Applications are invited for the above-named post from health visitors with experience of, or interest in, clinic administration and group teaching. The person appointed will be expected to take charge of one of the Corporation's Clinics and to take part in the group teaching undertaken by the Health Guidance section of the Health and Welfare Department, such teaching including some evening work. The salary (at present £30 above the ordinary health visitor scale) and conditions of service are in accordance with the recommendations of the Nurses and Midwives Whitley Council. Further information and forms of application may be obtained from the Medical Officer of Health, Willowbank House, Willowbank Road, Aberdeen, to whom applications should be sent within fifteen days of the appearance of this advertisement.

J. C. RENNIE
Town Clerk

Town House,
Aberdeen

WESTMINSTER HOSPITAL
TEACHING GROUP

Applications are invited from Staff Midwives for the Domiciliary Service, General and Private Wards.

Applications, with details of training, qualifications and experience, together with two Matron's names for reference, should be sent as soon as possible, to:

The Matron, Westminster Hospital, London, S.W.1.

CORPORATION OF THE CITY OF ABERDEEN

Health Visitor Training Course

There are still some vacancies in a course of training for the Health Visitor's Certificate, commencing in September, 1958, and continuing for approximately nine months.

Applications are invited from State Registered General Trained Nurses holding S.C.M. qualification or Part I C.M.B. Certificate for enrolment as Assisted or Non-Assisted Students.

Each Assisted Student will receive a maintenance allowance of £7 4*s.* 0*d.* weekly throughout the Course, together with her rail fare to the examination centre, and will be required to undertake to serve the Corporation as a Health Visitor for one year after qualifying.

The fee for the Course, payable by all students, is £10 10*s.* 0*d.*

Forms of application may be obtained from the Medical Officer of Health, Willowbank House, Willowbank Road, Aberdeen and should be returned to him within four weeks of the appearance of this advertisement.

J. C. RENNIE
Town Clerk

Town House,
Aberdeen

NORFOLK COUNTY COUNCIL

Applications are invited for vacancies in the undermentioned areas:—

District Nurse-Midwife/Health Visitor (preferably with Queen's & H.V. Certificates).

Hillington, Nr. King's Lynn. Unfurnished house.

Hockham, Nr. Thetford. Unfurnished house.

Massingham, Nr. King's Lynn. Unfurnished house.

Nordelph, Nr. Downham Market. House being built.

Oulton, Nr. Aylsham. Unfurnished house.

Snettisham, Nr. Hunstanton. Unfurnished house.

Southery, Nr. Downham Market. Unfurnished bungalow.

District Midwife.

King's Lynn. One of four. Unfurnished house.

District Nurse-Midwife.

Diss. Unfurnished house.

Fakenham. Increase of staff. One of three nurses living separately. Furnished accommodation.

Facilities available for Health Visitor and Queen's Nurse training with a view to generalised duties.

Staff needed for relief duties—holidays or longer periods.

Whitley Council salaries and conditions of service.

Successful applicants can use their own cars (loans available for purchase) or car can be provided.

Application forms from County Medical Officer, 29 Thorpe Road, Norwich.

BEDFORDSHIRE COUNTY COUNCIL
(Health Department)

HENLOW. DISTRICT NURSE/MIDWIFE. Newly built unfurnished house. Car driver essential. Further particulars and forms of application from: Divisional Medical Officer, "The Lawns" Health Centre, The Baulk, Biggleswade, Beds.

SECKFORD FOUNDATION

WANTED—For the Seckford Almshouses at Woodbridge, Suffolk, a senior nurse with S.R.N. or equivalent qualification. Experience as a District Nurse preferred. Maximum age 60. The duties would be to care for the alms-persons in 12 modernized quarters, and to supervise nursing attention, when required, in an adjacent building. Free accommodation in a self-contained flat, with free light and fuel. Further details on application to the Clerk of the Seckford Governors, Woodbridge, Suffolk.

Seckford Office,
73, Thoroughfare,
Woodbridge,
Tel. Woodbridge 777/8 Suffolk

EAST LONDON NURSING ASSOCIATION TRAINING HOME

Staff approximately 40 with District Nurse Tutor. Housekeeper employed.

(1) Assistant Superintendent required. H.V. Certificate. Good experience in general administration and in practical teaching. Motorist or willing to learn.

(2) Staff Midwife urgently required—Resident. Motorist.

Applications to the Deputy General Superintendent, Q.I.D.N., 57 Lower Belgrave Street, London, S.W.1.

LIVERPOOL QUEEN VICTORIA DISTRICT NURSING ASSOCIATION CENTRAL HOME

Assistant Superintendent required. H.V. Certificate. Good experience in general administration and in the practical teaching of Student Queen's Nurses. Possibilities of promotion. Accommodation provided in the first place. Motorist or willing to learn.

Applications to the Deputy General Superintendent, Q.I.D.N., 57 Lower Belgrave Street, London, S.W.1.

Please mention 'District Nursing' when replying to advertisements

TAILORED BY

Egerton Burnetts

WELLINGTON
SOMERSET

LONDON SHOWROOMS — 30 BUCKINGHAM PALACE ROAD — S.W.1